Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
15 – 23 April 2024
23 – 25 September 2024

Virtual Hearing

Name of Registrant:	Safina Michelle Clay
NMC PIN:	18B0584E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – April 2018
Relevant Location:	St Helens
Type of case:	Misconduct
Panel members:	Christine Nwaokolo (Chair, Lay member) Purushotham Kamath (Registrant member) Robert Marshall (Lay member)
Legal Assessor:	Georgina Goring / Marian Killen
Hearings Coordinator:	Khadija Patwary Vicky Green (16 April 2024) Hazel Ahmet (18 – 23 April 2024) Hazel Ahmet (23 – 25 September 2024)
Nursing and Midwifery Council:	Represented by Mr Tom Lambert (15-23 April 2024) and Mr Mohsin Malik (23-25 April 2024), NMC Case Presenters
Ms Clay:	Not present and unrepresented
Facts proved:	2a, 2b, 3, 5a, 5b, 6, 7a, 8, 9, 10a, 10b, 10c, 10d, 11a, 11b, 12, 13, 18, 19, 20, 21, 22 & 23.
Facts not proved:	1a, 1b, 4, 7b, 14, 15, 16 & 17.
Fitness to practise:	Impaired

Sanction:	Striking-off order
Interim order:	Interim suspension order (18 Months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Clay was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 14 March 2024.

Mr Lambert, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, as well as the date, time and details for joining the virtual hearing. Amongst other things, the Notice of Hearing included information about Ms Clay's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. The panel noted that Ms Clay had been provided with more than 28 days' notice of today's hearing.

In light of all of the information available, the panel was satisfied that Ms Clay has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Clay

The panel next considered whether it should proceed in the absence of Ms Clay. It had regard to Rule 21 and heard the submissions of Mr Lambert who invited the panel to proceed in the absence of Ms Clay.

Mr Lambert informed the panel that there had been no engagement by Ms Clay with the NMC in relation to this hearing and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel decided to proceed in absence of Ms Clay. In reaching this decision, the panel considered the submissions of Mr Lambert and the advice of the legal assessor. It had regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Clay;
- Ms Clay has engaged with the NMC previously however, she has not responded to any of the emails sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses have been scheduled to give oral evidence; not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred from February to June 2020 and therefore a further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

The panel recognises that there is some disadvantage to Ms Clay in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to Ms Clay at her registered email address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is because of Ms Clay's decisions to absent herself from the hearing, and consequently, she has waived her right to attend, and/or be represented.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Clay. The panel will draw no adverse inference from Ms Clay's absence in its findings of fact.

Background

The charges arose whilst Ms Clay was referred to the NMC in July 2020 by Colleague D and Colleague A whilst she was working as a registered nurse at Broad Oak Manor Care Home ('the Home'). The concerns relate to incidents when Ms Clay was working as a staff nurse at Broad Oak Manor Care Home. The allegations relate to Ms Clay's mismanagement of medication administration, record keeping issues, and consequent dishonesty.

Decision and reasons on application to amend charges

Mr Lambert made an application pursuant to Rule 28 of the Rules to amend charges 5, 18, 20 and 21. He submitted that the proposed amendments would more accurately reflect the evidence.

Charge 5 currently reads as follows:

22. *On 10 March 2020, recorded that you administered Resident B's Parkinson's medication at the incorrect time, in that you:*

    a. *Recorded the 16:00 dose as administered at 16:49,*
    b. *Recorded the 19:45 dose as administered at 16:52.*

The proposed amendment to charge 5 is as follows:

5. *On ~~10~~ **9** March 2020, recorded that you administered Resident B's Parkinson's medication at the incorrect time, in that you:*

    a. *Recorded the 16:00 dose as administered at 16:49,*
    b. *Recorded the 19:45 dose as administered at 16:52.*

Charge 18 currently reads as follows:

18. *On 30 May 2020, completed a medication competency form, naming Colleague B as the assessor, when they were not.*

The proposed amendment to charge 18 is as follows:

18. *On **or before** ~~30~~ **29** May 2020, completed a medication competency form, naming Colleague B as the assessor, when they were not.*

Charges 20 and 21 currently read as follows:

20. *On or after 30 May 2020, told colleagues that Colleague B had assessed you for your medication competency, when they had not.*

21. *On or after 30 May 2020, told colleagues that Colleague C had assessed you for your medication competency, when they had not.*

The proposed amendments to charges 20 and 21 are as follows:

20. *On or after ~~30~~ **29** May 2020, told colleagues that Colleague B had assessed you for your medication competency, when they had not.*

21. *On or after ~~30~~ **29** May 2020, told colleagues that Colleague C had assessed you for your medication competency, when they had not.*

The panel accepted the advice of the legal assessor.

The panel determined that the amendments, as applied for, were in the interests of justice. It found that the proposed amendments to the dates properly reflected the evidence before it. The panel was satisfied that there would be no prejudice to Ms Clay and no injustice would be caused to either party by the NMC's proposed amendment as they ensure that the charges accurately reflect the evidence.

Details of charges (as amended):

That you, a registered nurse:

1. On 23 February 2020:
    a) Failed to administer 1 or more Depakote tablets to Resident A,
    b) Failed to administer Parkinson's medication to Resident B.

2. On 2 March 2020:
    a) Failed to document Resident C's deterioration,

b) Failed to escalate Resident C's deterioration to a GP.

3. On 6 March 2020, left Carbocisteine unattended in Resident D's room.

4. On 9 March 2020, left paracetamol unattended in the dining room.

5. On 9 March 2020, recorded that you administered Resident B's Parkinson's medication at the incorrect time, in that you:

    a. Recorded the 16:00 dose as administered at 16:49,
    b. Recorded the 19:45 dose as administered at 16:52.

6. On an unknown date in March 2020, left pre-potted medication unattended in resident's rooms.

7. On 11 March 2020:
    a. Failed to properly apply dressings to 3 residents,
    b. Failed to document skin deterioration in respect of 1 of the residents in charge 7a.

8. On 16 March 2020, completed Resident E's medication administration history to confirm that you had administered Movicol to Resident E when you had not.

9. Your conduct at charge 8 was dishonest, in that you intended for anyone reading Resident E's medication administration history to believe that you had administered their Movicol when you had not.

10. On 17 March 2020:

    a. Removed a second dose of Resident E's Movicol;

b. Your conduct at charge 10.a was dishonest, in that you intended for anyone checking the stock of Resident E's Movicol to believe that you had administered their Movicol on 16 March 2020 when you had not;
c. Completed Resident F's medication administration history at 12:57 and/or 17:57 to confirm that you had administered their antibiotics when you had not;
d. Your conduct at charge 10.c was dishonest, in that you intended for anyone reading Resident F's medication administration history to believe that you had administered their antibiotics when you had not.

11. On 26 March 2020:

    a. Administered extra Adcal to Resident G instead of their prescribed antibiotic,
    b. Failed to complete a care plan review and/or basic risk assessment.

12. On 30 March 2020, failed to complete a care plan review.

13. On 12 May 2020, failed to document on Resident H's positional chart how often they were being turned.

14. On 14 May 2020, failed to administer Resident I's Parkinson's medication.

15. On 15 May 2020, told Colleague A that you had administered Resident I's Parkinson's medication on 14 May 2020 when you had not.

16. Your conduct at charge 15 was dishonest, in that you intended for Colleague A to believe that you had administered Resident I's Parkinson's medication on 14 May 2020 when you had not.

17. On 26 May 2020, failed to administer Resident I's Parkinson's medication.

18. On or before 29 May 2020, completed a medication competency form, naming Colleague B as the assessor, when they were not.

19. Your conduct at charge 18 was dishonest, in that you intended for anyone reading the medication competency form to believe you had been assessed by Colleague B, when you had not.

20. On or after 29 May 2020, told colleagues that Colleague B had assessed you for your medication competency, when they had not.

21. On or after 29 May 2020, told colleagues that Colleague C had assessed you for your medication competency, when they had not.

23. Your conduct at charges 20 and/or 21 above was dishonest, in that you intended for colleagues to believe that you had your medication competency assessed by Colleagues B and/or C.

24. On 6 or 10 June 2020, administered 80mg of Gliclazide to Resident J when they were prescribed 40mg of Gliclazide.

And, in light of the above, your fitness to practise is impaired by reason of your misconduct.

Witnesses

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Colleague D: Unit Manager at the Care Home, at the relevant time

- Colleague B: Staff Nurse within the Care Home, at the relevant time

Decision and reasons on application to admit the written statement of Colleague A into evidence as hearsay

After hearing evidence from all of the NMC witnesses, Mr Lambert made an application for the evidence of Colleague A to be admitted into evidence as hearsay. This application was made pursuant to Rule 31 of the Rules.

Mr Lambert drew the panel's attention to the NMC Guidance on *'Evidence',* in particular *'Hearsay'* Reference DMA-6 (Last updated 01 July 2022) and to the cases of *Thorneycroft v Nursing and Midwifery Council [2014]* EWHC 1565 (Admin) and *El Karout v NMC [2019] EWHC 28* (Admin).

Mr Lambert informed the panel that the NMC was made aware in February 2024 that Colleague A had sadly passed away and therefore unable to attend this hearing to give evidence. He drew the panel's attention to Colleague A's witness statement, her supplementary witness statement and the exhibits she provided.

Mr Lambert addressed the panel on principles of relevance and fairness and factors to consider in determining whether to admit hearsay evidence as set out in the NMC guidance and the case of *Thorneycroft*. Mr Lambert submitted that Colleague A's evidence is demonstrably reliable.

He submitted that whilst Colleague A's evidence is the sole and decisive evidence in respect of several charges, Colleague D has provided live evidence in relation to charges that are similar in nature. Mr Lambert submitted that Colleague A's evidence is demonstrably reliable and that there was no reason for her to fabricate her evidence. Whilst the evidence of Colleague A cannot be tested, Mr Lambert submitted that Ms Clay

or a representative is not present at this hearing and would therefore not be able to cross examine her in any event. He submitted that aside from some admissions made by Ms Clay in her responses set out in the NMC Case Management Form (CMF), there is no information about the nature and extent of any challenges to Colleague A's evidence.

Mr Lambert submitted that reasonable steps have been taken by the NMC to secure Colleague A's attendance. He drew the panel's attention to a number of communications between the NMC and Colleague A and submitted that if she was well and had not passed away then she would have attended this hearing to give evidence. Mr Lambert submitted that there is good reason for Colleague A's non-attendance.

Mr Lambert submitted that the panel should consider fairness to both Ms Clay and to the NMC as a regulator in meeting its overarching objectives including the protection of the public. He also submitted that it if the panel is minded to admit Colleague A's documentary evidence as hearsay evidence then it can decide what weight to ascribe to it at a later stage of the hearing.

The panel accepted the advice of the legal assessor.

The panel found that the documentary evidence of Colleague A is relevant. It is direct evidence, and also the sole and decisive evidence in respect of a number of charges. The panel reviewed all of the evidence before it and found that there was nothing to suggest that there was any grievance between Colleague A and Ms Clay and no reason for Colleague A to fabricate her evidence. It noted that Ms Clay had made some admissions to the facts set out in the charges that have arisen out of Colleague A's evidence. The panel also noted that Ms Clay has been sent the documentary evidence including Colleague A's witness statements and she has not objected to it going before the panel. As Ms Clay or a representative has not attended this hearing, the panel does not know the full nature and extent of any challenges other than some responses contained in the CMF.

In respect of fairness, the panel had regard to the seriousness of the charges and the potential outcome for Ms Clay if the charges were found proved. The panel was of the view that any unfairness to Ms Clay is outweighed by the need for the NMC to meet its objectives, namely, to protect the public and to uphold proper professional standards and satisfying the public interest. Having regard to all of the above the panel decided to admit the documentary evidence of Colleague A which it found to be demonstrably reliable. Once it has heard all of the evidence in this case, the panel will attach what weight it deems to be appropriate to Colleague A's evidence.

NMC's submissions on the facts

Charge 1a and 1b

Mr Lambert submitted that the panel has had both oral and documentary evidence which can be considered strong and reliable, consequently, finding all facts to be found proved. Mr Lambert submitted that it is a matter for the panel to determine what weight is given to Ms Clay's response to all of the charges, to the admissions or to her denials.

In relation to Charge 1a and 1b, Mr Lambert referenced Colleague D's evidence, submitting it to be a reliable source. Mr Lambert highlighted that Ms Clay's admissions for these two charges were reiterated through correspondence provided by Ms Clay's then RCN representative.

Mr Lambert pointed out that the denials for two of these charges had been changed. Therefore, it was submitted that as Ms Clay had reviewed the case management form submitted, and changed her responses to two charges, her admissions to the remaining charges must be given some weight.

Charge 2a

In relation to Charge 2a, Mr Lambert submitted that Colleague D's evidence can be relied on and highlighted the fact that the note made in Resident C's record, made by Ms Clay, did not properly reflect the resident's deterioration.

Mr Lambert submitted that Charge 2a can be found proved.

Charge 2b

In relation to Charge 2b, Mr Lambert submitted that there had been a failure to escalate Resident C's deterioration to a GP, with the oxygen saturation being recorded at 87%.

Mr Lambert submitted that Colleague D is a credible witness with no reason to doubt any of the evidence he has provided. Mr Lambert submitted that Ms Clay had been provided an opportunity to attend this hearing and give evidence and her side of events, however, given that she has chosen not to attend, there is no 'other side' to consider.

Mr Lambert submitted therefore that Charge 2b can be found proved.

Charge 3

In relation to Charge 3, Mr Lambert referred the panel to Colleague D's statement whereby he wrote that the night nurse had found Carbocisteine unattended in a pot, outside of room 29.

Mr Lambert relied on the evidence of Colleague D and stated that the charge can be found proved.

Charge 4

In relation to Charge 4, Mr Lambert submitted that Ms Clay had left paracetamol unattended in the dining room and this was found by the night nurse in the early hours of 9 March 2020. Mr Lambert referred the panel to Colleague D's statement which states that this misconduct is 'a very basic training matter', and not something that requires an extensive, induction process.

Mr Lambert submitted that this witness evidence is sufficient to find this charge proved.

Charge 5a and 5b

In relation to Charge 5a, Mr Lambert submitted that Ms Clay admitted this charge.
Mr Lambert submitted that Colleague D had stated that Resident B's Parkinson's medication was administered 49 minutes after it should have been at 16:49pm as opposed to 16:00. Colleague D stated that the more serious error was the 19:45pm medication having been administered at 16:52, not only three hours early, but only three minutes after Resident B was administered her first dose.

Consequently, Mr Lambert submitted that Charge 5a can be found proved.

In relation to Charge 5b, Mr Lambert submitted that Ms Clay denied this charge. However, given the fact that one of the allegations is admitted, and can be found proved, Mr Lambert submitted that the other should also be found proved.

Charge 6

In relation to Charge 6, Mr Lambert referred to the witness statement of Colleague D, whereby he stated that multiple pre-potted pots of medication were found unattended in residents' rooms. Colleague D had stated that it was only him, Ms Clay, and one other colleague on duty on this unknown date. Mr Lambert submitted therefore, that the only possible registered nurse who could have left such medication pots unattended, would have been Ms Clay.

Mr Lambert submitted that there is contemporaneous evidence, in the form of Colleague D's notes, which supports this charge.

Mr Lambert submitted that Charge 6 can be found proved.

Charge 7a and 7b

In relation to Charge 7a and 7b, Mr Lambert addressed these charges together. He referenced the exhibit bundle, submitting that it had been reported that Ms Clay had applied dressings to some residents on the ward, whilst leaving some residents with no dressing applied to their wounds. Mr Lambert highlighted that the documentation had suggested that all relevant dressings had been applied to all residents who required it. Mr Lambert highlighted an example of this, where Ms Clay had recorded that she had completed the dressings for room 41 and room 27, however, night staff had found these residents without any dressings on.

Mr Lambert submitted that this misconduct can be considered as dishonest, and therefore, Charges 7a and 7b can be found proved.

Charge 8, 9, and 10

In relation to Charge 8, 9, and 10, Mr Lambert made joint submissions on these charges. Mr Lambert submitted in relation to Charge 8 and 9, that there was evidence to show that Ms Clay had completed Resident E's medication administration history, to confirm that she had administered Movicol to the resident, when she had not. Mr Lambert submitted that Ms Clay had intended for anyone reading the medication history of Resident E, to believe that she had been administered Movicol, when she had not. Mr Lambert submitted that there can be no other intention in filling out the administration history with false information, apart from dishonesty.

In relation to Charge 10, Ms Clay had denied both 10a and 10b, however had admitted Charge 10c and 10d.

Mr Lambert submitted that the panel should take into consideration the witness evidence of Colleague D, and the claims made by Ms Clay herself, whereby she claimed to have administered certain medications to her residents, even though she had not done so.

Mr Lambert highlighted that a full sealed box with 20 tablets was found, whereas Ms Clay had signed the notes to state that she had been administering antibiotics, as and when they should have been. Nonetheless, the box was found full, with all 20 tablets, when the night staff attended for their duty.

Mr Lambert submitted that Ms Clay's attempted efforts to 'cover up' mistakes that had occurred, may be seen to demonstrate a more 'guilty mind'. He stated that any reasonable person observing Ms Clay's behaviour in these three charges would deem that to be dishonest.

Consequently, Charges 8, 9, and 10 can be found proved in their entirety.

Charge 11a and 11b

In relation to Charge 11, Mr Lambert highlighted that Ms Clay had admitted to both parts of charge 11.

Mr Lambert submitted that on Colleague D's statement demonstrates that Ms Clay had not been acting in the manner she was required to, and this is supported by the relevant contemporaneous notes.

Mr Lambert submitted that Charge 11 can be proven in its entirety.

Charge 12

In relation to Charge 12, Mr Lambert submitted that Ms Clay has admitted to this charge.

Mr Lambert submitted that the panel should consider the witness statements, which makes it clear that Ms Clay failed to complete a care plan review. He submitted that the witness statements can also be relied upon as they describe the facts of the alleged charge and further confirm that Ms Clay held the attitude that there was no urgency to complete the task of a care plan review. Mr Lambert submitted that Ms Clay was listening to music in the computer room, seemed distracted and had a lack of consistency within her work.

Mr Lambert submitted that Charge 12 can be found proved.

Charge 13

At the outset of the submissions for this particular charge, Mr Lambert requested that the date be changed from 12 May 2020 to 9 May 2020.

Mr Lambert submitted that in relation to Charge 13, the panel should rely on the witness hearsay bundle. He stated that Colleague A's statement makes clear that Ms Clay did not follow the positional charts for Resident H during her shift. Ms Clay deviated from the expected sequence.

Consequently, Mr Lambert submitted that Charge 13 can be found proved.

Charge 14 and 15

Mr Lambert in relation to Charge 14 submitted that this charge is admitted, whilst Charge 15 is denied by Ms Clay.

Mr Lambert submitted that the panel should take into consideration Colleague A's hearsay statement, whereby she claimed that Ms Clay failed to administer Resident I's Parkinson's medication. It was submitted that the medication had not been given as confirmed through a physical check of the tablets and a cross reference with the system.

Mr Lambert submitted that when confronted, Ms Clay initially claimed that she had given the medication, but then changed her claim and stated that she *'must not have'.*

Mr Lambert submitted that Charges 14 and 15 can be found proved.

Charge 16 and 17

Mr Lambert in relation to Charge 16 and Charge 17, submitted that these charges are denied by Ms Clay.

Mr Lambert submitted that Ms Clay's conduct at Charge 15 was inherently dishonest, and therefore Charge 16 can be found proved. Mr Lambert submitted that Charge 17 can be found proved given the same reasoning as the previous Charge 16.

Charge 18, 19, 20, 21, and 22

Mr Lambert considered Charges 18, 19, 20, 21 and 22 together, as he submitted that these are linked to more serious charges against Ms Clay.

Mr Lambert submitted that these charges involve multiple incidents, multiple individuals and multiple alleged deceptions. Mr Lambert stated that the panel, in finding these charges proved, can rely on the hearsay bundle, witness evidence, and the internal local statement.

Mr Lambert submitted that the significant charge out of the above is the one which relates to medication competency. He stated that Ms Clay's name was on an assessment form

and marked as completed by Colleague B, whilst Colleague B has denied this and stated that this was not her handwriting. Ms Clay had then admitted that she had falsely written Colleague B's name, without her knowledge.

Mr Lambert highlighted that Ms Clay took leave and then handed in her notice shortly after, with a denial of ever having had any involvement in signing off a medication competency form.

Mr Lambert submitted that Ms Clay's actions in respect of these charges were fundamentally dishonest, and that all the witnesses *'could not be conspiring against'* Ms Clay.

Mr Lambert submitted that Charge 18, 19, 20, 21 and 22 can be found proved.

Charge 23

Mr Lambert submitted in relation to Charge 23, that there had been no explanation by Ms Clay. He submitted that the panel could rely on the witness evidence and the hearsay bundle to find this charge proved.

Mr Lambert submitted that although the evidence for this charge has not been challenged by Ms Clay, it would be difficult to do so given the credibility of the witnesses in this case.

Consequently, Mr Lambert submitted that Charge 23 can be found proved.

Mr Lambert concluded that all the charges against Ms Clay can be found proved by the panel on the balance of probabilities.

Panel's decision and reasons on the facts

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

The panel has drawn no adverse inference from the non-attendance of Ms Clay. The panel considered Ms Clay's response as set out in the CMF, however, in relation to all of the allegations, the panel has first considered the primary evidence as presented by the NMC and Ms Clay, before going on to consider any admissions made by Ms Clay. The panel were mindful that the burden remains upon the NMC to prove their case, despite any admissions made by Ms Clay in the CMF.

The panel then considered each of the charges and made the following findings.

Charge 1a

1. *On 23 February 2020:*
    a) *Failed to administer 1 or more Depakote tablets to Resident A,*

In considering Charge 1a, the panel reviewed the Colleague D's statement; his handwritten notes and Resident A's MAR (Medication Administration Record) Chart. The panel noted that Colleague D had stated that the registered nurse on night duty on the 23 February 2020, (through to the morning of 24 February 2020), found two Depakote tablets in the medicine trolley.

The panel noted from the witness evidence and Resident A's MAR Chart that on 23 February 2020, Ms Clay had been the registered nurse administering medication during the day shift, and on the 23 February 2020, at both 08:00 and 16:00, made an entry on to Resident A's MAR chart that she had administered Depakote tablets.

The panel reviewed the Resident A MAR Chart and noted that on the 22 February 2020 at 16:00 Ms Clay had signed the chart indicating that Resident A had refused their two Depakote tablets.

The panel considered that the two tablets found on the medication trolley, could be the two Depakote tablets refused by Resident A on the 22 February 2020 as Ms Clay had signed the MAR Chart as to this refusal. The panel did not have access to Resident A's Admin History Chart and could not therefore determine a count of the tablets. In his witness statement Colleague D indicates he was not able to provide any more detail on this incident and his handwritten note referred to *'2 x Depakote left in medicine trolley'.*

Given all of the information before it, the panel determined that Ms Clay had indeed not administered the two Depakote tablets on the 22 February 2020, which resulted in two tablets being left in the medicine trolley, but she has indicated a valid reason why she had not given the tablets-the resident had refused. These tablets were then found the following day in the medicine trolley, the 23 February 2020, by the night registered nurse.

The panel concluded, that on the balance of probabilities, this charge is not proven.

Charge not proved.

Charge 1b

b) Failed to administer Parkinson's medication to Resident B.

In relation to Charge 1b, the panel took into account the witness statement of Colleague D and his handwritten notes.

The panel noted that there was no Resident B MAR chart provided for 23 February 2020, nor is there an associated Resident B administration history chart for this date. The panel had Resident B's MAR Chart that covered the period between 1 March to 31 March 2020 only. Colleague D indicated that he was not able to provide any more detail on this incident and his handwritten note referred to *'RM9 Stanek not given'.* In Colleague D's oral evidence, he confirmed that Resident B was in room 9.

The panel determined that in relation to this charge, the evidence before it is solely the statement of Colleague D stating Ms Clay had failed to administer Resident B's Parkinson's medication, with no supporting evidence.

Consequently, the panel determined that, on the balance of probabilities, this charge is not proven.

Charge not proved.

Charge 2a

2. *On 2 March 2020:*
    a) *Failed to document Resident C's deterioration,*

In considering Charge 2a, the panel noted that Colleague D's witness statement was further confirmed through his live, oral witness evidence.

The panel noted that Ms Clay did not document or make reference to Resident C's abnormal oxygen saturation of 87% within her documents or raise any clinical concern as a result of this oxygen saturation. The panel did however note that it does not have an observations chart, nor the clinical notes of the 2 March 2020.

However, the panel highlighted that they do have Colleague D's statement and his contemporaneous handwritten notes. The panel found Colleague D's oral evidence credible, and his answers regarding the expectations from a registered nurse to be very helpful and clear. The panel noted that Colleague D was able to explain the NEWS and was knowledgeable, with his statement reflecting his oral evidence.

The panel determined that this charge is found proved.

Charge proved.

Charge 2b

b) Failed to escalate Resident C's deterioration to a GP.

In relation to Charge 2b, the panel reflected on Colleague D's evidence that is contained in his written statement, and also his oral evidence, where he was particularly questioned on matters of policy relating to escalation of incidents as well as his explanation as to how NEWS is used in the unit, and what is expected of a registered nurse.

The panel was also mindful that Colleague D was frank in that the induction training was not as robust as he would have preferred, given that the time that Ms Clay joined was during the COVID-19 era. However, the panel noted that Colleague D remained clear in the expectations that were required of a registered nurse, and therefore, of Ms Clay.

The panel noted that Colleague D stated in his evidence, that at the very least, Ms Clay had a responsibility to escalate the issues Resident C was facing on 2 March 2020 to a GP, but she did not do so.

Consequently, based on Colleague D's evidence, and in considering the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 3

3. On 6 March 2020, left Carbocisteine unattended in Resident D's room.

In relation to Charge 3 the panel looked at Colleague D's statement, whereby he wrote *'On the 6 March 2020 the night nurse found Carbocisteine which is an anti-mucus*

medication in the room of Resident D. This occurred whilst Safina was on duty.' It further considered Colleague D's handwritten note which again makes reference to the medication being left in Room 29, which in evidence from Colleague D, confirms that this was Resident D's room.

The panel determined that it did not have sufficient evidence to determine who had specifically left Carbocisteine unattended in Resident D's room. The panel noted that there was another registered nurse working on duty on this date, and it was their role also to administer the Carbocisteine medication.

The panel considered Resident D's MAR chart as an exhibit, and that on 6 March 2020, Ms Clay was on duty and is recorded to have administered medication to Resident D at 16:00. The panel however also noted that earlier that day at 08:00 another registered nurse was on duty and had signed for the administration of the medication to Resident D.

The panel further noted that Ms Clay is reported to have left the medication unattended.

Therefore, in light of the above evidence available to the panel, and on the balance of probabilities, this charge is found proved.

Charge proved.

Charge 4

4. *On 9 March 2020, left paracetamol unattended in the dining room.*

In relation to Charge 4, the panel determined that there is insufficient evidence to support that it was Ms Clay who had specifically left paracetamol unattended in the dining room on 9 March 2020. The panel further noted that there is no context to this allegation.

The panel concluded therefore, that on the balance of probabilities, this charge is not found proved.

Charge not proved.

Charges 5a and b

5. *On 9 March 2020, recorded that you administered Resident B's Parkinson's medication at the incorrect time, in that you:*

    a. *Recorded the 16:00 dose as administered at 16:49,*
    b. *Recorded the 19:45 dose as administered at 16:52.*

In reaching its decision on this charge, the panel considered Colleague D's statement and gave his handwritten note detailing the incident. The panel further considered the MAR charts before it and noted that they clearly showed the times in which the medication was administered by Ms Clay.

The panel further considered the MAR charts before it and noted that they clearly show the times in which the medication was administered by Ms Clay, alongside Colleague D's statement and handwritten notes.

The panel concluded therefore, that on the balance of probabilities, these charges are found proved.

Charges proved.

Charge 6

6. *On an unknown date in March 2020, left pre-potted medication unattended in resident's rooms.*

In relation to Charge 6, the panel determined that there is sufficient evidence in Colleague D's statement, and also within his contemporaneous hand-written notes which refers to supervision he had completed with Ms Clay, which specifically dealt with the matter of pre-potting of medication.

The panel further considered Ms Clay's reflective account and determined that whilst she tries to justify having left pre-potted medication unattended in resident's rooms on an unknown date, there is some acceptance that this did occur.

The panel concluded therefore, that on the balance of probabilities, this charge is found proved.

Charge proved.

Charge 7a

7. *On 11 March 2020:*
    a. *Failed to properly apply dressings to 3 residents,*

In relation to Charge 7a, the panel found that it fell within a registered nurses remit to properly apply a dressing to a patient, and that it would be expected for Ms Clay to have documented that in each of the residents' care plans.

The panel further considered the evidence of Colleague D, who in his statement states that three residents were found not to have proper dressings applied.

When questioned at the time of the incident, Ms Clay responded and stated that she did not apply dressings to the three residents, but that she had requested help in relation to doing so.

Consequently, based on these various pieces of evidence, and in considering the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 7b

b. *Failed to document skin deterioration in respect of 1 of the residents in charge 7a.*

In relation to Charge 7b, the panel considered Colleague D's statement and handwritten notes and noted that there were inconsistencies contained in these documents. Colleague D in his written statement, it states that there was no documentation in respect of the skin deterioration, however, in his hand-written notes he also states the following: *'documented R22 dressing changed inaccurate documentation […] wrong dressing being used]'.*

Due to this inconsistency and without any other corroborating evidence, the panel cannot be satisfied that the NMC has proven its case in respect of Charge 7b.

The panel concluded therefore that given the lack of evidence before it, and on the balance of probabilities, this charge is not found proved.

Charge not proved.

Charge 8

8. *On 16 March 2020, completed Resident E's medication administration history to confirm that you had administered Movicol to Resident E when you had not.*

In relation to Charge 8, the panel considered the administration history of Resident E, and found that Ms Clay had recorded, on 16 March 2020 at 16:25, that she had in fact administered Movicol to this resident.

Analysis of the administration history showed that after Colleague D had given Resident E one dose of Movicol, there should have been 18 remaining in the box (if Ms Clay had given one dose as required). In fact, there were 19 doses remaining after Colleague D had administered one dose, proving that Ms Clay did not administer Resident E one dose of her medication.

The panel further took into account Colleague D's statement and notes; he stated that there was a full box (20 sachets) of the Movicol medication after Ms Clay had recorded to have provided Resident E with their dosage. Colleague D stated that Ms Clay, after having been challenged, stated that she 'must not have given it'.

Consequently, in considering the evidence before it and on the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 9

9. *Your conduct at charge 8 was dishonest, in that you intended for anyone reading Resident E's medication administration history to believe that you had administered their Movicol when you had not.*

In relation to Charge 9, the panel took into account Colleague D's witness evidence, whereby he stated that *'On the 16 March 2020 Safina signed the resident notes for Resident E to say that her medication Movicol had been administered, this could not have been given as this was a new box and factory sealed.'*

The panel noted that Ms Clay provided an explanation as to why she had not administered the Movicol medication to Resident E, only after having been challenged and questioned. The panel has at the forefront of its mind, the two-stage test for dishonesty as set out in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67, (Ivey).

I. The panel must ascertain (subjectively) the actual state of the Registrant's knowledge or beliefs as to the facts. The reasonableness of the belief is a matter of evidence going to whether she genuinely held the belief, but it is not a requirement that the belief must be reasonable.
II. Once the actual state of mind is determined, the question is whether the Registrants conduct was honest or dishonest by applying the standards of ordinary decent people.

The panel took into consideration the NMC guidance on considering dishonesty, and in doing this, considered that, at the time, Ms Clay did know that she would have needed to record administering medication, as she was familiar with the system. The panel noted that Ms Clay requested help but were further mindful that she had used the system properly.

In respect of evidence of alternative explanations, the panel felt it did not have that or have any statements from Ms Clay explaining her actions. Ms Clay was not in attendance to give any oral evidence, and the panel relied on Colleague D's statement and Resident E's administration history.

The panel determined that Ms Clay would have known that what she was doing was dishonest and that, by the standards of ordinary decent people, her conduct would be

considered dishonest. It was therefore satisfied that the test for dishonesty in Ivey had been met.

The panel determined that Ms Clay had acted dishonestly.

Consequently, in considering all of the evidence before it and on the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 10a

10. On 17 March 2020:

a. Removed a second dose of Resident E's Movicol;

In relation to Charge 10a, the panel took into account Colleague D's statement and his hand-written notes, alongside the medication administration history in relation to Resident E. The panel determined that a second dose of Resident E's Movicol was removed in order to disguise the mistakes Ms Clay had made in the previous Charge 8.

The panel noted that this mistake was discovered by Colleague D whilst he was administering the Movicol medication. The panel found that on 17 March 2020 at 10:12, one sachet of medication was administered by Colleague D from a sealed box of 20, which would have taken the count to 19 sachets. The panel further noted that one dose of medication was administered on the same date at 16:59 by Ms Clay, which should have taken the count to 18 sachets. However, the panel noted that on 18 March 2020 Colleague D claimed Ms Clay to have given one dose, which would have lowered the count to 17. However, Colleague D states that he in fact found that two doses had been removed as stock level was 16, as opposed to 17, which results in one dose having not been accounted for, and possibly administered and not recorded. Colleague D stated that

he felt Ms Clay was trying to correct her mistaken lack of administration of this medication by trying to make the stock count add up to what it should have been.

Consequently, in considering all of the witness evidence before it, and on the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 10b

> b. *Your conduct at charge 10.a was dishonest, in that you intended for anyone checking the stock of Resident E's Movicol to believe that you had administered their Movicol on 16 March 2020 when you had not;*

In relation to Charge 10b, the panel determined that there is no reasonable explanation as to why the stock count would be higher than it was due to be. In turn, this stock count can be considered as evidence that a second dose of Resident E's Movicol was in fact removed, and that such an action was dishonest. The panel determined that Ms Clay would have known that what she was doing was dishonest and that, by the standards of ordinary decent people, her conduct would be considered dishonest. It was therefore satisfied that the test for dishonesty in Ivey had been met.

Consequently, in considering the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 10c

c. *Completed Resident F's medication administration history at 12:57 and/or 17:57 to confirm that you had administered their antibiotics when you had not;*

During consideration of Charge 10c, the panel noted that there was a discrepancy in the times in this charge which needed clarification. The panel invited Mr Lambert to make representations in respect of this and concluded that it would amend the charge to accurately reflect the timings set out within the evidence. Mr Lambert sought to amend the charge to state:
'On 17 March 2020: c) Completed Resident F's medication administration history ***on or around*** *12:57 and/or 17:57 to confirm that you had administered their antibiotics when you had not.'*

The panel accepted the advice of the legal assessor. The panel agreed to the amendment.

In relation to Charge 10c, the panel considered the witness statements before it, and the fact that the administration was filled in by Ms Clay to state that she did administer the antibiotic, wrongfully. Furthermore, this charge was admitted by Ms Clay.

The panel concluded therefore, that on the balance of probabilities, this charge is found proved.

Charge proved.

Charge 10d

d. *Your conduct at charge 10.c was dishonest, in that you intended for anyone reading Resident F's medication administration history to believe that you had administered their antibiotics when you had not.*

In relation to Charge 10d, the panel determined that there is no alternative for the conduct in this charge other than dishonesty, in that Ms Clay intended for others to believe that she had intended to administer the antibiotics which she had not. The panel noted that this was dishonesty by the standards of ordinary, honest nurses. The standard for a registered nurse is to be truthful, and honest.

The panel concluded therefore, that on the balance of probabilities, this charge is found proved.

Charge proved.

Charge 11a

11. On 26 March 2020:

a. *Administered extra Adcal to Resident G instead of their prescribed antibiotic,*

In considering Charge 11a, the panel took account of the administration history for Resident G. The panel took account of the entries for 26 March 2020, noting that the counts recorded that there was one extra medication than the amount that had been recorded.

The panel further took into consideration Colleague D's statement, whereby he recalled a conversation with Ms Clay in which she had admitted to not giving the antibiotic medication to Resident G but had given extra Adcal instead. The panel determined that this was confirmed by the fact that the stock count for Adcal was down by one tablet. The panel further noted that this evidence is strengthened by Colleague D's handwritten contemporaneous note, which further explains this discrepancy.

Consequently, based on these various pieces of evidence, and in considering the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 11b

b. Failed to complete a care plan review and/or basic risk assessment.

In considering Charge 11b, the panel took into account the witness statement and handwritten notes of Colleague D, whereby he stated that the care plan review had not been completed for Resident G, nor had the basic risk assessment been completed. The panel further noted that this charge was admitted by Ms Clay, and in the context of this charge, she accepted that she did not complete the care plan, nor did she complete the risk assessment.

Consequently, in considering the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 12

12. On 30 March 2020, failed to complete a care plan review.

In relation to Charge 12, the panel determined that it is reasonable to expect that a basic task given to a registered nurse within Ms Clay's role, must be completed. The panel noted that the nursing process consists of assessment planning, implementation and evaluation. It would be expected that Ms Clay would be able to complete a Care Plan Review and risk assessments.

The evidence provided by Colleague D showed that Ms Clay had been given time to complete the Care Plan Review but did not do so; she left the room where she had been working and listening to music.

Therefore, in considering the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 13

13. *On 12 May 2020, failed to document on Resident H's positional chart how often they were being turned.*

At the outset of considering this charge, the panel decided to amend the date from 12 May 2020 to 9 May 2020, having accepted an application from the NMC.

In relation to Charge 13, the panel noted that Ms Clay was on duty as a registered nurse on 9 May 2020. The panel took into consideration the statement of Colleague A in relation to this charge, and the fact that she challenged Ms Clay on her failure to document on Resident H's positional chart and how often they were being turned.

The panel was mindful that Ms Clay accepted that she did not do what was expected of her as a registered nurse, in relation to this charge, however, gave the explanation that it was due to a lack of staff. The panel noted that the local investigation concluded that whilst some staff members were not available, it was for short periods of time and that this did not justify a lack of positional moves over the period that Ms Clay was on duty.
The panel was mindful that it does not have primary evidence, it is relying on hearsay evidence which it has not been able to fully explore. The panel noted that there was a root cause analysis [RCA] that had been completed in to this incident. It also took into account that; Ms Clay is not in attendance to represent herself.

However, in considering the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 14

14. On 14 May 2020, failed to administer Resident I's Parkinson's medication.

In considering Charge 14, the panel noted that it has not received any evidence from Ms Clay regarding the conversation between herself and Colleague A. The panel noted that before it, there is primary evidence in the form of Resident I's MAR chart. Whilst looking at the entries, the panel noted that the record shows that the Parkinson's medication which was due to be administered at 18:00 on 14 May 2020, was recorded as not administered. However, it was Colleague A that signed the medication as not given and had recorded 14:11 as the time. The panel noted that, in looking at the MAR chart records, it is clear that Ms Clay did administer the first two doses of Resident I's Parkinson's medication earlier on 14 May 2020. However, Ms Clay was not involved in the non-administration of third dose.

The panel noted that there is no administration history chart for the date in question, 14 May 2020, and that although it considered the evidence before it, the panel cannot conclude that it was specifically Ms Clay who failed to administer Resident I's Parkinson's medication. The panel lack the primary evidence of a valid administration record. Consequently, in considering the balance of probabilities, the panel determined that this charge is not found proved.

Charge proved.

Charges 15 and 16

15. *On 15 May 2020, told Colleague A that you had administered Resident I's Parkinson's medication on 14 May 2020 when you had not.*

16. *Your conduct at charge 15 was dishonest, in that you intended for Colleague A to believe that you had administered Resident I's Parkinson's medication on 14 May 2020 when you had not.*

Given that Charge 14 was found not proved on the balance of probabilities, both Charge 15 and Charge 16 are also found not proved as there is no finding of facts that Ms Clay had not administered Resident I's Parkinson's medication.

Charges not proved.

Charge 17

17. *On 26 May 2020, failed to administer Resident I's Parkinson's medication.*

In considering Charge 17, the panel considered the witness statement of Colleague A, which referred to an incident on 26 May 2020, whereby Parkinson's medication was not administered to Resident I. The panel considered the MAR chart for Resident I, and could see entries for the date of 26 May 2020, and noted that, according to the key provided with the MAR chart, there were other registered nurses apart from Ms Clay who were responsible for administering the Parkinson's medication to Resident I on this date.
The panel considered the hand-written notes of Colleague A, whereby there was an entry on 26 May 2020 stating that the medication count was *'all wrong'.* However, the panel noted that these notes do not specifically refer to the Parkinson's medication, or detail in any way how the count was *'all wrong'.*

The panel further noted that it did not have an administration history for Resident I covering the date of 26 May 2020, as the administration history began on 27 May 2020

onwards. The handwritten note made by Colleague A on 27 May 2020 referred merely to a conversation with Ms Clay 'regarding yesterday's medication situation', with Colleague A stating, *'I also stated that one resident had not had her Parkinson medication on at least 5 occasions, I asked if she knew why and she couldn't give me an answer.'* The panel considered that this entry does not provide any specific detail about the medication error in Charge 17.

Consequently, the panel determined that it does not have any specific evidence that Ms Clay had failed to administer Resident I's Parkinson's medication. The panel also noted that when Ms Clay was asked about this charge, there was no admission made.
In light of the evidence the panel, and the fact that it was unable to identify any discrepancies on the specific date of 26 May 2020, it concluded that on the balance of probabilities, this charge is not proved.

Charge not proved.

Charge 18

18. *On or before 29 May 2020, completed a medication competency form, naming Colleague B as the assessor, when they were not.*

In relation to Charge 18, the panel took into consideration that Colleague B had provided a written statement and typed notes, claiming that she had seen the medication competency form with her name signed on it, however, she had not completed the form herself and the signature had not been signed by her.

The panel considered that Ms Clay was confronted about this allegation, and changed her account, further stating that it was actually Colleague C who had completed the medication competency form.

The panel noted Colleague D's evidence in his witness statement, whereby he confirmed that Colleague C had not conducted the medication competency assessment; *'I did not lead on the investigation on this issue although I am aware of all the details, but I did assist in the matter, speaking with [Colleague C] to confirm that she had not conducted the medication competency assessment with Safina.'*

The panel concluded therefore that considering all of the evidence before it, and on the balance of probabilities, this charge is found proved.

Charge proved.

Charge 19

19. *Your conduct at charge 18 was dishonest, in that you intended for anyone reading the medication competency form to believe you had been assessed by Colleague B, when you had not.*

In relation to Charge 19, the panel found felt that Ms Clay had acted dishonestly. In her written statement, Colleague B stated that she had not completed the medication competency form, in respect of Ms Clay. Further to this, in her oral evidence, Colleague B again confirmed that she had not completed the medication competency form. The panel determined that Ms Clay knew that Colleague B had not completed the medication competency form and intended to make others believe that she had completed it.
The panel determined that Ms Clay would have known that what she was doing was dishonest and that, by the standards of ordinary decent people, her conduct would be considered dishonest. It was therefore satisfied that the test for dishonesty in Ivey had been met.

The panel concluded therefore that considering all of the evidence before it, and on the balance of probabilities, this charge is found proved.

Charge proved.

Charge 20

20. On or after 29 May 2020, told colleagues that Colleague B had assessed you for your medication competency, when they had not.

In relation to Charge 20, the panel considered the typed note of Colleague A, that Ms Clay was questioned around the medication competency completion by this colleague sometime on or around 29 May 2020. The panel noted that Ms Clay had initially claimed that Colleague B had assessed her for her medication competency when this was untrue. The panel noted that Ms Clay then changed her account for the completion of the medication competency sheet, stating that it was Colleague C instead of Colleague B. It was considered that Ms Clay had written Colleague B's name, as Colleague C was an agency nurse and unable to sign a medication competency sheet.

Consequently, in considering the evidence provided by Colleague A, and on the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 21

21. On or after 29 May 2020, told colleagues that Colleague C had assessed you for your medication competency, when they had not.

In relation to Charge 21, the panel noted that Colleague A had discussed with Colleague D Ms Clay's claim, that Colleague C had signed the medication competency sheet. Colleague D in his witness statement said that a statement was sought and received from Colleague C, whereby she denied having completed this medication competency sheet with Ms Clay. Colleague C stated that she was first alerted to this when management

spoke with her regarding the sheet, and she confirmed that she had never worked alongside Ms Clay as she mainly worked on the night duty.

The panel determined that Ms Clay would only have had communication with Colleague C during a handover period between shifts, which would make the completion of a medication competency sheet having been completed together, not probable.

The panel finally considered the witness evidence of Colleague D, whereby he wrote: *'It was discovered that Ms Clay had forged her medication competency assessment forms to say that she was competent when it was found that the medication competency assessment had not taken place. I did not lead on the investigation on this issue although I am aware of all the details, but I did assist in the matter, speaking with … to confirm that she had not conducted the medication competency assessment with Ms Clay.'*

The panel concluded therefore that considering all of the evidence before it, and on the balance of probabilities, this charge is found proved.

Charge proved.

Charge 22

22. *Your conduct at charges 20 and/or 21 above was dishonest, in that you intended for colleagues to believe that you had your medication competency assessed by Colleagues B and/or C.*

In relation to Charge 22, the panel considered that Ms Clay's conduct in Charge 20 and Charge 21 was dishonest. The panel took into account the case of Ivey and considered the state of mind of Ms Clay, and whether or not she was aware of her conduct when she made the claims that Colleague B and Colleague C where they had stated that they had not completed the medication competency sheet.

The panel determined that Ms Clay would have known that what she was doing was dishonest, and that, by the standards of ordinary decent people, her conduct would be considered as dishonest. The panel was satisfied that the test for dishonesty in Ivey has been met.

Consequently, in considering the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Charge 23

23. On 6 or 10 June 2020, administered 80mg of Gliclazide to Resident J when they were prescribed 40mg of Gliclazide.

In considering Charge 23, the panel first considered the statement from Colleague A in the hearsay bundle.

The panel noted that Resident J should have received an 80mg dose of Gliclazide in the morning, and an 40mg dose in the afternoon. The panel determined that Ms Clay wrongly administered Resident J with 80mg of Gliclazide at 16:00, which is twice the amount of dosage they should have been given.

The panel noted that this evidence is corroborated in the administration history for Resident J. The panel noted that the hearsay bundle shows that on 6 June 2020 after Ms Clay had administered the 80mg of Gliclazide to Resident J, there were 15 tablets left in the packet. However, on 7 June 2020, when another nurse had administered one tablet, there were only 13 tablets left, which shows that one tablet was missing, and that there was less medication left in the packet than there should have been. Therefore, it was concluded that this evidence confirms the allegation that Ms Clay had given 80mg of

Gliclazide in the afternoon instead of 40mg in the afternoon, and hence one tablet was consequently missing.

Consequently, in considering all of the evidence before it and the balance of probabilities, the panel determined that this charge is found proved.

Charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Clay's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Clay's fitness to practise is currently impaired as a result of that misconduct.

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

The panel accepted the advice of the legal assessor.

Submissions on misconduct

Mr Malik invited the panel to take the view that the facts found proved amount to misconduct.

Mr Malik identified the specific, relevant standards where Ms Clay's actions amounted to misconduct.

Mr Malik, in addition to his oral submissions, provided the following in a written form:

> *'1. We invite the panel to take the view that the facts found proved amount to misconduct.*
>
> *2. The Panel will be aware that the professional standards of practice and behaviour for nurses, midwives and nursing associates sets the professional standards that patients and public tell the NMC that they expect.*
>
> *3. The panel will be familiar with the leading case of Roylance v GMC [1999] UKPC 16 where Lord Clyde provided guidance when considering what could amount to misconduct.*
>
> *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [Nurse] practitioner in the particular circumstances'.*

4. Further assistance may be found in the comments of Jackson J in Calhaem v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin):

"[Misconduct] connotes a serious breach which indicates that the [nurse's] fitness to practise is impaired"

and

"The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners".
5. The NMC assert that here, Ms Clay's, acts, falls short of the standards set out in The Code: Professional standards of practice and behaviour for nurses and Midwives (2015) ("The Code")

6. Due to Ms Clay falling short of "the Code", what she did, we say, amounts here to serious professional misconduct.

7. Practising effectively and upholding the nursing profession is a fundamental nursing responsibility and it was the professional duty of Ms Clay to ensure that she acted in a manner that was appropriate for a nursing professional.

8. The Panel have already fully reviewed the evidence and it is not necessary to recite all of the facts here. However, I would draw your attention that the panel found that on the balance of probabilities Ms Clay failed to document Resident C's deterioration and failed to escalate Resident C's deterioration to a GP. Ms Clay had a responsibility to escalate the issues Resident C was facing to a GP but she did not do so.

9. The panel found that Ms Clay left pre-potted medication unattended in resident's room and she failed to properly apply dressings to three residents and the panel found that it fell within a registered nurse's remit to properly apply a dressing to a patient, and that it would be expected for Ms Clay to have documented that in each of the residents' care plans.

10.The charge found proved that Ms Clay recorded that she had in fact administered Movicol to Resident E when she had not, is very serious that could have caused serious harm to Resident E. Ms Clay provided an explanation, only after having been challenged and questioned. Furthermore, the panel considered that, at the time, Ms Clay did know that she would have needed to record administering medication, as she was familiar with the system. The panel determined that Ms Clay would have known that what she was doing was dishonest.

11.It has been found that Ms Clay removed a second dose of Resident E's Movicol. The panel determined that a second dose of Resident E's Movicol was removed in order to disguise the mistakes Ms Clay has made.

12.Ms Clay also completed Resident F's medication administration history to confirm that she has administered their antibiotics when she had not. The panel found that Ms Clay intended for others to believe that she had intended to administer the antibiotics which she had not.

13.Ms Clay failed to complete a Care Plan Review, the panel determined that it is reasonable to expect that a basic task given to a registered nurse within Ms Clay's role must be completed. This was basic nursing and it would be expected that Ms Clay would be able to complete a Care Plan Review and risk assessments.

14.It was found that Ms Clay completed a medication competency form, naming Colleague B as the assessor, when they were not. The panel determined that Ms

Clay knew that Colleague B had not completed the medication competency 4 form and intended to make others believe that she had completed it. Ms Clay would have known that what she was doing was dishonest.

15.The facts found proved involve a number of concerns relating to medication administration, record keeping, dressings, escalating deteriorating conditions, and dishonesty.

16.The panel found four charges of dishonesty proved. We say the dishonesty raises fundamental concerns about the Ms Clay's trustworthiness as a registered professional.

17.Ms Clay's actions demonstrate a pattern of sustained dishonest and unprofessional behaviour. Dishonest Conduct goes against the spirit of the NMC code and can be difficult to remediate.

18.The misconduct is a serious departure from the Code, and fellow practitioners would consider such a departure deplorable.

19.The misconduct is serious because honesty and integrity are fundamental tenets of the profession. The public expect nurses to be truthful, and honest.

20.The panel will be aware that seriousness is an important concept which informs various stages of our regulatory processes. The public's trust and confidence in all nurses, demonstrating the behaviour found by Ms Clay here must, we assert, amount to a serious misconduct.

"The Code" (2015)

21.The NMC say that "The Code" has been breached. We would suggest that the following particular areas of the code being engaged are;

22.Section 1-Treat people as individuals and uphold their dignity

To achieve this you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

Section 10 – Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

Section 13-Recognise and work within the limits of your competence
13.2 make a timely referral to another practitioner when any action, care or treatment is required.

Section 20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code
20.2 act with integrity at all times, treating people fairly and without discrimination, bullying or harassment

23.I would respectfully ask the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.'

Submissions on impairment

Mr Malik moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Malik, in relation to impairment, provided oral submissions, along with the following written submissions:

'Impairment

24.The Panel are now considering whether Ms Clay's fitness to practise 'is impaired' (Art 22(1)(a) of the Nursing and Midwifery Order 2001).

25.Impairment is not defined in the legislation.

26.There have been many legal cases which have developed the concept of impairment and the factors that should be considered when deciding whether a

professional's fitness to practise is impaired. The question that will help decide whether a professional's fitness to practise is impaired is:

"Can the nurse, midwife or nursing associate practise Kindly, safely and professionally?"

27.Consideration has been given to the nature of the concern by looking at the factors set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J;

A summary is set out in the case at paragraph 76 in the following terms:

"Do our findings of fact in respect of the [nurse's] misconduct, deficient professional performance, adverse health, conviction, caution, or determination show that his/her fitness to practise is impaired in the sense that s/he:

i. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
ii. has in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or
iii. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the [nursing] profession;
iv. has in the past acted dishonestly and/or is liable to act dishonestly in the future

28.We say all 4 limbs of grant are engaged by the circumstances of this case.

29. If the panel make the decision on the facts that Misconduct is found. The panel will next be deciding whether the professional's fitness to practise is impaired. The NMC represent that this question is answered positively. The NMC represent that

the professional's fitness to practise is impaired particularly by way of D above, Dishonesty.

Limb i

30.Ms Clay's actions have put patients at unwarranted risk of harm, failing to escalate Resident C's deterioration to a GP, leaving Carbocisteine unattended in Resident D's room, recording the incorrect time for Resident B's medication, leaving pre-potted medication unattended in resident's rooms, recording that medication had been administered to Resident's when it was not, administering extra Adcal to Resident G instead of their prescribed antibiotic put patients at unwarranted risk of harm and had the potential to cause serious harm to patients. In the absence of full insight and remediation the risk of repetition and future harm remains.

Limbs ii and iii

31.Miss Clay's actions have brought the nursing profession into disrepute and she has breached fundamental tenets of the nursing profession by failing to promote professionalism and trust (not keeping to and upholding the standards and values as set out in The Code) and acting in a thoroughly dishonest manner.

32.Registered professionals occupy a position of trust in society. The public, quite rightly, expects nurses to provide safe and effective care, and conduct themselves in a way that promotes trust and confidence. The conduct that has been found proved in this case undermines the public's trust and confidence in the profession and could result in patients, and members of the public, being deterred from seeking nursing assistance when needed.

Limb iv

33.The NMC considers that there is a continuing risk to both public protection and the wider public interest due to Ms Clay's actions which are directly linked to her clinical practice and dishonesty in this case. Intending for anyone reading Resident E's medication administration history to believe that she had administered their Movicol when she had not, intending for anyone reading Resident F's medication administration history to believe that she had administered their antibiotics when she had not, and intending colleagues to believe that she had her medication competency assessed by colleagues B and C are difficult elements to remediate. Her behaviour raises fundamental concerns about her attitude as a registered professional and Ms Clay has failed to address and put right the issues raised. The behaviour also demonstrates serious breaches of trust. Further, the concerns demonstrate fundamental dishonesty which undermines or completely erodes public trust and confidence in the profession.

34.A decision about whether a professional's fitness to practise is impaired takes a holistic approach, so that anything that's relevant is considered. It is dependent on the individual circumstances surrounding each concern.

35.The panel will no doubt ask themselves if any part of the CODE has been breached or is liable to be breached in the future. Any breach would be considered alongside other relevant factors.

36.The NMC refer the panel to the earlier concerns on the breaches of the CODE.

37.The NMC say that the breaches of the Code involve breaching a fundamental tenet of the profession, the panel would be entitled to conclude that a finding of impairment is required in Ms Clay's case. The finding of impairment, the NMC assert, is required to mark the unacceptability of the behaviour, emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards or behaviour (see Yeong v GMC [2009] EWHC 1923 (Admin) Hamer para 36.07).

Remorse, reflection, insight, training and remediation

38.With regard to future risk, the panel are invited to consider the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) namely (i) whether the concerns are easily remediable; (ii) whether they have in fact been remedied; and (iii) whether they are highly unlikely to be repeated.

39.The failings involved in this case are directly linked to her clinical practice and attitudinal. They relate to dishonest conduct and a breach of the duty of candour, and are therefore more difficult to remediate. The NMC's guidance entitled "Serious concerns which are more difficult to put right (FTP-3a)" lists breaching the professional duty of candour to be open and honest when things go wrong as a concern that is so serious that it may be less easy for a nurse, midwife or nursing associate to put right the conduct.

40.The NMC's guidance entitled "Insight and strengthened practice (FTP-13)" states "Evidence of the nurse, midwife or nursing associate's insight and any 10 steps they have taken to strengthen their practice will usually be central to deciding whether their fitness to practise is currently impaired".

41.The panel should consider to what extent Ms Clay had reflected upon events and had demonstrated insight into what happened, together with steps taken to remediate the concerns. Ms Clay has not submitted a reflection statement to the panel, and maintains that she did not intend to deliberately mislead or deceive.

42. As such, the misconduct is not easily remediable. Breaching the professional duty of candour includes covering up or falsifying records when things go wrong. It is further submitted that the concerns have not been remediated and are therefore highly likely to be repeated should Ms Clay be permitted to practise as a nurse again.

43.I would highlight to the panel that the Registrant denied all the dishonesty charges. There is no evidence that she has addressed or taken steps to address any concerns or risks identified in the case.

Public protection impairment

44.A finding of impairment is necessary on public protection grounds as the misconduct in this case is serious and there remains a risk of repetition of the relevant misconduct due to Ms Clay's limited insight and lack of remediation. The panel found four dishonesty allegations proved which was directly linked to her clinical practice. Therefore, the risk of unwarranted harm to the public remains, as explained above.

Public interest impairment

45.A finding of impairment is also necessary on public interest grounds. 11 In accordance with Article 3(4) of the Nursing and Midwifery Order 2001 ("the Order") the overarching objective of the NMC is the protection of the public and Article 3(4A) provides:

"The pursuit by the Council of its overarching objective involves the pursuit of the following objectives
a) to protect, promote and maintain the health, safety and well-being of the public;
b) to promote and maintain public confidence in the professions regulated under this Order; and
c) to promote and maintain proper professional standards and conduct for members of those professions."

46.The case of Grant acknowledges that, in order to protect the public there must be a separate consideration of the wider relevant public interest issues. Cox J stated at para 71:

"It is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations … namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession"

47.At paragraph 101 of Grant Cox J commented that:

“The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case”.

48.Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold 12 proper professional standards and conduct and/or to maintain public confidence in the profession.

49.A finding of impairment is necessary on public interest grounds in this case. Breaching the professional duty of candour by falsifying records is deplorable and amounts to serious misconduct. The conduct of Ms Clay has brought the nursing profession into disrepute and served to undermine public confidence and trust in the profession.

50.The dishonesty occurred in her workplace. This raises fundamental questions about her integrity and trustworthiness as a registered professional and seriously undermines public trust in nurses, midwives and nursing associates. The wider concern was that the she had knowingly been recording something within resident’s records that was not true.

For these reasons the NMC say that Ms Clay's practice is currently impaired.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow [2007] QB 462 (Admin).*

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Ms Clay's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Clay's actions amounted to several breaches of the Code, specifically the following parts:

1) Treat people as individuals and uphold their dignity
1.2) *make sure you deliver the fundamentals of care effectively*
1.4) *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

3) Make sure that people's physical, social and psychological needs are assessed and responded to
3.1) *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

6) Always practise in line with the best available evidence
6.1) *make sure that any information or advice given is evidence-based, including information relating to using any health and care products or services*

6.2) *maintain the knowledge and skills you need for safe and effective practice*

10) keep clear and accurate records relevant to your practice

10.1) *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

10.2) *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

10.3) *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

13) recognise and work within the limits of your competence

13.1) *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

13.2) *make a timely referral to another practitioner when any action, care or treatment is required*

13.3) *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

19) Be aware of, and reduce as far as possible, any potential for harm associated with your practice

19.1) *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

20) uphold the reputation of your profession at all times

20.1) *keep to and uphold the standards and values set out in the Code*

20.2) *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel determined that the concerns in this case are serious, and that the finding of dishonesty, in particular, is serious. The panel noted that, for a registrant to conceal and/or attempt to conceal a series of medication errors and then falsify competency documents would have an adverse impact on public confidence in the nursing profession as well as protection of the public. The panel determined that this dishonesty suggests that Ms Clay has an attitudinal issue.

The panel considered the charges found proven, which relate to the mismanagement of medication. It noted that the impact of such a concern is serious, as this could have led to the harm of the residents under Ms Clay's care, alongside having possibly led to lack of staff confidence in what medications have and have not been administered for residents under their care.

The panel determined that the failings found proved in this case, such as the lack of care planning, Ms Clay's response and failure to escalate the deterioration of a resident, the inaccurate recording of medication administration and the lack of honesty, are fundamental aspects of care and conduct expected from a registered nurse.

The panel found that Ms Clay's actions did fall seriously short of the conduct and standards expected of a nurse and consequently, amounted to misconduct.

Decision and reasons on impairment

The panel next considered whether, as a result of its finding of misconduct, Ms Clay's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
>
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
>
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are always expected to protect the public, uphold and maintain standards of care and practice and maintain public confidence in the nursing profession. Patients and their families must be able to trust nurses with their health and wellbeing and that of their loved ones. To justify that trust, nurses must be honest, open and act with integrity. They must make sure that their conduct always justifies both their patients' and the public's trust and confidence in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's “test” which reads as follows:

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel found that the charges found proven regarding handling and administration of medication, documentation and escalation of resident deterioration, properly applying dressings, and care plan and positional chart completion, all put residents at unwarranted risk of harm. As such, the panel found that the first limb is engaged.

Secondly, the panel determined that the charges found proven regarding handling and administration of medication, documentation and escalation of patient deterioration, properly applying dressings, and care plan and positional chart completion, all would bring the nursing profession into disrepute. The panel also found that the charges relating to dishonesty, where Ms Clay reported a medication competency form as having been

signed, which was not true, would bring the nursing profession into disrepute. The panel determined that a member of the public would expect a nurse to be competent in all these aspects of nursing practice, and to be honest in the work that they do. The panel therefore found that the second limb is engaged, and Ms Clay's actions have brought the nursing profession into disrepute.

Thirdly, the panel has identified the fundamental tenets that have been breached by Ms Clay, noting that a registered nurse should be able to complete risk assessments for a resident and care plan effectively; should be honest about the status of competency documents that they have and have not legitimately completed, they should know when and how to respond and escalate to a situation relating to a residents health, they should understand the importance of timely administration of medication and they should also provide the correct medication. Therefore, the panel find that the third limb is engaged.

Finally, the panel has found that Ms Clay was dishonest in relation to four charges. The fourth limb is therefore engaged.

The panel determined therefore, that all four limbs of Dame Janet Smiths ''test'' are engaged.

The panel was satisfied that the misconduct in this case, which includes findings of dishonesty, whilst difficult to remediate, is not impossible. The panel carefully noted the evidence before it in determining whether Ms Clay's fitness to practice is currently impaired. Regarding insight, the panel noted that Ms Clay has not provided an updated reflective piece regarding the concerns that were raised. The panel has not been provided with any evidence other than three training certificates dated in 2021, in which she completed training on Assessing Needs, Safe Administration of Medicines and Pain Management. Further, the panel noted that Ms Clay has not provided any current evidence of remediation, insight, or strengthening of practice.

The panel is of the view that there is a risk of repetition because Ms Clay has not provided any level of up-to-date insight or strengthening of practice relating to the concerns raised against her. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in the circumstances of this case and therefore also finds Ms Clay's fitness to practise impaired on the grounds of public interest.

Having regard to all the above, the panel was satisfied that Ms Clay's fitness to practise is currently impaired.

Sanction

The panel has considered this case carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Clay off the register. The effect of this order is that the NMC register will show that Ms Clay has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and also had regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, the NMC had advised Ms Clay that it would seek the imposition of a striking-off order if the panel found Ms Clay's fitness to practise currently impaired. The NMC submit that the appropriate and proportionate sanction in this case remains to be a striking-off order.

Mr Malik submitted that the aggravating features in this case are as follows:

- The dishonesty in this case was directly related to Ms Clay's clinical practice;
- The sustained dishonest conduct/attitudinal concerns are difficult to remediate;
- The multiple incidents involved in this case and;
- The risk of patient harm.

Mr Malik submitted that the mitigating feature in this case is as follows:

- Ms Clay made some minor admissions in her 2021 reflective statement.

Mr Malik submitted that dishonesty is a serious matter, and therefore it would neither be proportionate, nor in the public interest to take no further action. He submitted that this case is not at the lower end of the spectrum of impairment of fitness to practice.
Mr Malik submitted that this case involves several concerns relating to medication administration, record keeping, dressings, escalating deteriorating conditions, and dishonesty.

Mr Malik submitted that dishonesty is a type of concern that is difficult to remediate and following the panel's finding of facts on the charges of dishonesty, Ms Clay requires to reflect more carefully on this aspect of the charges which were found proved.

Mr Malik submitted that there are no areas of practice in need of assessment or training, but rather, the issues in this case are more fundamental. He submitted therefore, that given the serious nature of the concerns in this case, there are no workable conditions that could be formulated. He further noted that, the panel have determined that there is a risk

of repetition in this case, and therefore, for the protection of the public, a conditions of practice order would not be appropriate.

Mr Malik submitted that a suspension order would not be appropriate in this case, as Ms Clay's concerns relate to harmful and deep-seated personality/attitudinal problems, evidence of repetition of misconduct, and a lack of insight with a real risk of harm. Mr Malik submitted that the concerns in this case are serious, and that they do not relate to an isolated incident; Ms Clay has not presented any real insight. A suspension order is therefore inappropriate, and Ms Clay's conduct is not compatible with remaining on the register.

Mr Malik submitted that Ms Clay's misconduct has raised fundamental questions into her integrity and professionalism. He highlighted that Ms Clay's dishonesty did not occur in a moment of panic, but rather was a sustained course of conduct, only ended when discovered by her employers. Mr Malik submitted that Ms Clay's actions were a significant departure from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The public confidence in the nursing profession cannot be maintained if Ms Clay is not removed from the register.

Mr Malik submitted that in all of the circumstances, a striking-off order is the only appropriate and proportionate order.

Decision and reasons on sanction

Having found Ms Clay's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel identified the following aggravating factors in Ms Clay's case:

- The charges found proven demonstrate that Ms Clay has shown limited insight;
- Ms Clay's conduct put residents at risk of suffering harm and;
- Four of the charges found proven amount to dishonesty and therefore, evidence a deep-seated attitudinal concern.

The panel then identified the following mitigating factors in Ms Clay's case:

- Ms Clay has made some minor admissions early on in this NMC process.

Having regard to the sanction's guidance, the panel first considered whether to take no action but concluded that this would be inappropriate and insufficient in view of the seriousness of the case. The panel determined that the facts found proven in this case highlight a real risk of harm and a deep-seated attitudinal concern. The panel decided that it would neither protect the public nor be in the public interest to take no further action.

The panel then considered the imposition of a caution order. It determined that due to the seriousness of the case and the public protection and public interest issues identified, such as a finding of dishonesty with a corresponding deep seated attitudinal concern, and several instances of clinical misconduct, that posed a risk of and/or actual harm to the residents, it would not be appropriate. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Clay's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Clay's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the findings in this case. The misconduct identified in this case was not something that can be addressed through retraining, particularly given the finding of deep-seated attitudinal concerns and proven facts which result in a finding of dishonesty. Furthermore, the panel concluded that the placing of conditions on Ms Clay's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that Ms Clay's behaviour was not confined to an isolated incident. It has found that Ms Clay has limited insight and does pose a risk of repetition.

In this case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel were of the view that Ms Clay's actions were a significant departure from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel noted that the dishonesty in this case is serious and presents an element of deep-seated attitudinal concerns; a nurse is expected to uphold honesty and integrity at all times of their career. Further, the panel noted that Ms Clay has displayed several instances of wide-ranging misconduct which were sustained over a short period of time, such as the lack of care planning, the failure to escalate the deterioration of a resident, the inaccurate recording of medication administration and the dishonesty related to her clinical practice.

The panel noted that Ms Clay has not responded to this stage of this NMC process, in that Ms Clay has provided a very limited amount of engagement and has failed to present any insight since her previous reflective piece in 2021. The panel has no evidence before it in the form of an update in relation to Ms Clay's clinical practice; therefore, the risk of repetition in this case is high; there is no indication of any clinical improvement.

The panel was of the view that the findings in this case demonstrate that Ms Clay's actions were serious and to allow her to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all these factors and after considering all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Clay's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should

conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Ms Clay in writing.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel considered the length of time needed for an interim order. It considered the submissions made by Mr Malik and noted that if an appeal is lodged, 18 months would be needed to cover the appeal period.

The panel therefore imposed an interim suspension order for a period of 18 months.

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Ms Clay is sent the decision of this hearing in writing.

That concludes this determination.